DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **03-14**

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: **Title XIX of the Social Security Act (Medicaid)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2003**

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY '03 $ 940
b. FFY '04 $ 3,750

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 19.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 19.

10. SUBJECT OF AMENDMENT:

Change in Attachment 4.19-B in relation to reimbursement rates for certain clinics.

11. GOVERNOR'S REVIEW *(Check One)*
[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
Barry S. Maram

13. TYPED NAME: **Barry S. Maram**

14. TITLE: **Director of Public Aid**

15. DATE SUBMITTED

16. RETURN TO:
Illinois Department of Public Aid
Bureau of Program and Reimbursement Analysis
Attn: Frank Kopel, Chief
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **09-30-03**

18. DATE APPROVED: 12/23/03

PLAN APPROVED—ONE COPY ATTACHED /

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME: **Cheryl A. Harris**

22. TITLE: **Associate Regional Administrator**
Division of Medicaid an Children's Health

23. REMARKS:

RECEIVED
SEP 30 2003
DMCH - IL/IN/OH

FORM CMS-179 (07/92)

Instructions on Back

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -OTHER TYPE OF CARE -BASIS FOR REIMBURSEMENT

07/98 f. Special Reimbursement Requirements for Services Provided in Hospital Emergency Room and Clinic Settings.

i. When emergency room services are provided to clients, the hospital is required to code any fee-for-service claims with the emergency room place of service.

07/03 g. Hospital-Based Organized Clinic Reimbursement.

i. With respect to hospital-based organized clinics that qualify as Maternal and Child Health Clinics, payment shall be made in accordance with Section 1(a)(iv) of this attachment.

ii. With respect to all other hospital-based organized clinics, payment shall be in accordance with the fee-for-service reimbursement described in Section 1 of this attachment.

07/03 hg. Encounter Rate Clinic Reimbursement

07/03 i. For encounter rate clinics providing comprehensive health care for women and infants ~~or encounter rate clinics operated by a county with a population of over three million~~, payment shall be made at the lesser of:

07/03 A. ~~$50.00~~ $75.00 per encounter; or

07/03 B. The clinic's charge to the general public.

07/98 ii. For all other encounter rate clinics, payment shall be made at the lesser of:

07/98 A. The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

07/98 B. $50.00 per encounter; or

07/03 C. The clinic's charge to the general public.

07/98 ih. Psychiatric clinic reimbursement

Reimbursement shall be made under the federally qualified health center methodology if the clinic meets the criteria as an FQHC. Otherwise the clinic shall be reimbursed as an encounter rate clinic.